PATIENT REGISTRATION

Patient Last Name:_____ **First Name**_____

Sex: **F** ○ **M** ○ **Date of Birth:**_____ **Age** _____ **Social Security #**_____

Address:_____**City**_____**State**_____ **Zip Code**_____

Home Phone: _____ **Work Phone** _____ **Cell** _____

Marital Status: **S** ○ **M** ○ **D** ○ **W** ○ **Employer Name:**_____

Referred by:_____ **Personal Physician:**_____

FOR CHILDREN UNDER THE AGE OF 18: In the event of an emergency, and I cannot be contacted, I give my permission to the doctors or the persons under their instruction to treat my child in their office or hospital as required by the events of that emergency situation.

Parent's signature:_____

GUARANTOR (RESPONSIBLE PARTY) INFORMATION

Name:_____ **Relationship to Patient:**_____

Sex: **F** ○ **M** ○ **Date of Birth:** _____ **Social Security #** _____

Address:_____**City**_____**State**_____ **Zip Code**_____

Home Phone: _____ **Work Phone:**_____ **Cell** _____

Employer Name: _____

PRIMARY INSURANCE INFORMATION

Insurance Name:_____ **ID#** _____ **Group #** _____

Address: _____ **Phone #:**_____

Subscriber Name: _____ **Employer:** _____ **Social Security #** _____

Effective Date: _____ **Subscriber Birth date:** _____ **Relationship to patient:** _____

SECONDARY INSURANCE INFORMATION

Insurance Name:_____ **ID#** _____ **Group #** _____

Address: _____ **Phone #:**_____

Subscriber Name: _____ **Employer:** _____ **Social Security #** _____

Effective Date: _____ **Subscriber Birth date:** _____ **Relationship to patient:**_____

MEDICAL RELEASE AUTHORIZATION

I AUTHORIZE THE Adult and Pediatric Allergy Center of Northern Virginia to apply for benefits on my behalf for covered services rendered. I request payment be made directly to the above named provider. I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this of any related claim, to the above named billing agent and or the insurance company named above. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me of the above named carrier at any time in writing. I understand I will be responsible for all charges made for services as well as all costs of collections and reasonable attorney fees (minimum $15) if this account is placed in the hands of an attorney.

_____ _____

Signature Date

Adult and Pediatric Allergy Center of Northern Virginia; 100 Elden Street, Suite 10; Herndon, VA 20170

HEALTH HISTORY

Name_____ Age _____ Today's Date _____
Birth Date _____ Date of last physical examination _____ Primary Care Dr. _____

I. Check the problem(s) which bring you to our office:

☐ Anaphylaxis (shock) ☐ Asthma ☐ Ear problems ☐ Eczema ☐ Eye problems ☐ Food Allergy
☐ Hives ☐ Polyps ☐ Rhinitis ("Hay fever") ☐ Serum sickness ☐ Sinusitis (sinus infections)
☐ Stinging Insect Allergy ☐ Swelling ☐ Other _____

II. MEDICATIONS (List medications you are currently taking, including all over the counter and supplements):_____

_____

_____

III. ALLERGIES (To medications or substances): _____

_____

IV. SYMPTOMS (Check symptoms you currently have or have had in the past year):

GENERAL
☐ Chills
☐ Depression
☐ Dizziness
☐ Fainting
☐ Fever
☐ Forgetfulness
☐ Headache
☐ Loss of sleep
☐ Nervousness
☐ Numbness
☐ Sweats
☐ Weight loss

SKIN
☐ Bruise easily
☐ Hives
☐ Itching
☐ Change in moles
☐ Rash
☐ Scars
☐ Sore that won't heal

GASTROINTESTINAL
☐ Appetite poor
☐ Bloating
☐ Constipation
☐ Diarrhea
☐ Excessive hunger
☐ Excessive thirst
☐ Gas
☐ Hemorrhoids
☐ Indigestion
☐ Nausea
☐ Rectal bleeding
☐ Stomach pain
☐ Vomiting
☐ Vomiting blood

WOMEN ONLY
Are you pregnant? Yes ☐ No ☐

EYE/ EAR/ NOSE/ THROAT
☐ Bleeding gums
☐ Blurred vision
☐ Crossed eyes
☐ Difficulty swallowing
☐ Double vision
☐ Earache
☐ Ear discharge
☐ Hay fever
☐ Hoarseness
☐ Loss of hearing
☐ Nosebleeds
☐ Persistent cough
☐ Ringing in ears
☐ Sinus problems
☐ Vision – flashes
☐ Vision – halos

MUSCLE/JOINT/BONE
Pain, weakness, numbness in:
☐ Arms ☐ Hips
☐ Back ☐ Legs
☐ Feet ☐ Neck
☐ Hands ☐ Shoulder

GENITO-URINARY
☐ Blood in urine
☐ Frequent urination
☐ Lack of bladder control
☐ Painful urination

CARDIOVASCULAR
☐ Chest pain
☐ High blood pressure
☐ Irregular heart beat
☐ Low blood pressure
☐ Poor circulation
☐ Rapid heart beat
☐ Swelling of ankles
☐ Varicose veins

V. CONDITIONS (Check conditions you have or have had in the past):

☐ AIDS
☐ Alcoholism
☐ Anemia
☐ Anorexia
☐ Appendicitis
☐ Arthritis
☐ Asthma
☐ Bleeding Disorders
☐ Breast Lump
☐ Bronchitis
☐ Bulimia
☐ Cancer
☐ Cataracts
☐ Chemical Dependency
☐ Chicken Pox
☐ Diabetes
☐ Ear infections
☐ Emphysema
☐ Epilepsy
☐ Glaucoma
☐ Goiter
☐ Gonorrhea
☐ Gout
☐ Heart Disease
☐ Hepatitis
☐ Hernia
☐ Herpes
☐ High blood pressure
☐ High cholesterol
☐ HIV positive
☐ Hives
☐ Kidney disease
☐ Liver disease
☐ Lupus
☐ Measles
☐ Migraine headaches
☐ Miscarriage
☐ Mononucleosis
☐ Mumps
☐ Pacemaker
☐ Pneumonia
☐ Polio
☐ Prostate problem
☐ Psychiatric care
☐ Recurrent upper respiratory tract infections
☐ Recurrent sinus infections
☐ Rheumatic fever
☐ Scarlet fever
☐ Skin rashes
☐ Stroke
☐ Suicide attempt
☐ Thyroid problems
☐ Tonsillitis
☐ Tuberculosis
☐ Typhoid fever
☐ Ulcers
☐ Vaginal infections
☐ Venereal disease

VI. FAMILY HISTORY:

Fill in health information about your family:

Relation	Age	State of health	Age at Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

Check if your blood relative had any of the following:		
	Disease	**Relationship to you**
☐	Asthma, hay fever	
☐	Cancer	
☐	Chemical dependency	
☐	Diabetes	
☐	Heart Disease	
☐	High Blood Pressure	
☐	Kidney Disease	
☐	Lupus/Rheumatoid Arthritis	
☐	Pulmonary (lung) Disease	
☐	Tuberculosis	
☐	Other	

VII. HOSPITALIZATIONS/SURGERIES:

Year	Reason for hospitalization or surgery

VIII. PATIENT SOCIAL HISTORY:

1. Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
2. Use of alcohol: ☐ Never ☐ Rarely ☐ Moderate ☐ Daily
3. Use of tobacco: ☐ Never ☐ Previously, but quit ☐ Current, packs/day____
4. Use of drugs: ☐ Never Type/ Frequency _____
5. Excessive exposure at home, work or school to: ☐ Fumes ☐ Dust ☐ Solvents ☐ Airborne particles ☐ Smoke
6. Your occupation:_____

IX. ENVIRONMENTAL HISTORY:

1. Age of your home:_____ How long have you lived there? _____
2. Your home is a(n): ☐ Detached home ☐ Apartment ☐ Townhouse
3. Heat at home is (check all that apply): ☐ Forced warm air (central heating) ☐ Electric baseboard ☐ Wood stove ☐ Radiator (steam/hot water)
4. Air conditioning at home: ☐ None ☐ Central ☐ Window units, _____ Bedroom _____ Living room/family room
5. Humidifier at home: ☐ None ☐ Central (furnace) ☐ Room unit, location _____
6. Air cleaner/purifier at home: ☐ None ☐ Central (furnace) ☐ Room unit, location _____
7. Type of mattress on the patient's bed: ☐ Regular ☐ Air mattress ☐ Waterbed ☐ Other_____ Age of mattress_____
8. Dust mite covers? ☐ Yes ☐ No If yes, they are on ☐ Mattress ☐ Box Springs ☐ Pillows ☐ Comforters
9. Type of pillow on the patient's bed: ☐ Foam/ fiber-filled ☐ Feather ☐ Other_____ Age of pillow _____
10. Type of comforter on the patient's bed: ☐ Down-filled ☐ Polyester fill ☐ Cotton fill ☐ Other _____
11. Carpeting: In the home: ☐ Wall to wall ☐ Area rug ☐ None
    Patient's bedroom: ☐ Wall to wall ☐ Area rug ☐ None
12. What fur-bearing pets do you have? ☐ None ☐ Cat(s) ☐ Dog(s) ☐ Other _____
13. Do you have feathered pets? ☐ No ☐ Yes
14. Do these pets have access to the patient's bedroom? ☐ Never ☐ Sometimes ☐ Often

AT THIS TIME BELOW IS A LIST OF INSURANCE COMPANIES THAT WE PARTICIPATE WITH:

AETNA CHOICE POS II
AETNA HEALTHFUND
AETNA OPEN ACCESS ELECT CHOICE EPO
AETNA OPEN ACCESS MANAGED CHOICE
AETNA OPEN CHOICE PPO
AETNA TRADITIONAL CHOICE INDEMNITY
**** We do not participate in ALL Aetna Products. It is your responsibility to call before being seen to confirm participation and benefits.**

ANTHEM BC/BS PPO
ANTHEM BC/BS FEDERAL EMPLOYEE
ANTHEM BC/BS TRIGON PPO

BLUE CROSS BLUE SHIELD PPO

CCN PPO
CIGNA PPO
CIGNA OPEN ACCESS

FIRST HEALTH PPO

GEHA PPO
GREAT WEST PPO

HUMANA PPO

MAMSI HEALTH AND LIFE PPO
MULTIPLAN PPO

NCPPO

ONE HEALTH PPO
ONE NET

PHCS PPO
PRINCIPAL PPO

NALC

UNITED HEALTHCARE PPO
UNITED HEALTH CARE SELECT AND SELECT PLUS (POS AND EPO)
UNICARE PPO

THE FOLLOWING ARE A LIST OF HMO's OR MANAGED CARE COMPANIES WE PARTICIPATE WITH:

AETNA ELECT CHOICE EPO
AETNA MANAGED CHOICE POS
ANTHEM TRIGON HMO
BC/BS CAPITAL CARE OR BLUE CHOICE HMO
CAREFIRST
CIGNA HMO
HEALTHKEEPERS HMO
OPTIMUM CHOICE
UNITED HEALTHCARE CHOICE AND CHOICE PLUS HMO

IF YOU ARE A MEMBER OF ONE OF THE ABOVE HMO PLANS IT IS **YOUR RESPONSIBILITY** TO HAVE AN UP TO DATE AND ACCURATE REFERRAL AT THE TIME OF YOUR APPOINTMENT. IF YOU HAVE NOT OBTAINED A REFERRAL, IT IS EXPIRED, OR DID NOT BRING IT WITH YOU; YOU WILL BE RESPONSIBLE FOR ALL CHARGES.

WE DO NOT GUARANTEE PARTICIPATION, BENEFITS, OR COVERAGE WITH INSURANCE COMPANIES. IT IS THE PATIENT'S/PARENT'S RESPONSIBILITY TO CONFIRM OUR PARTICIPATION AND BENEFITS WITH THEIR INSURANSE COMPANY.

WE SUGGEST THAT YOU CALL THE PHONE NUMBER ON THE BACK OF YOUR INSURANCE CARD TO CONFIRM OUR PARTICIPATION AND YOUR BENEFITS PRIOR TO YOUR APPOINTMENT.

IF YOU PARTICIPATE WITH AN INSURANCE COMPANY NOT LISTED ABOVE WE WILL FILE YOUR CLAIM AS A COURTESY. YOU WILL BE RESPONSIBLE TO PAY YOUR BILL IN FULL AT THE TIME OF THE APPOINTMENT.

WE DO NOT PARTICIPATE IN ANY **MEDICAID** PLANS.
WE HAVE OPTED OUT OF **MEDICARE**. NO BENEFITS WILL BE PAID BY MEDICARE. PLEASE SEE FRONT DESK STAFF FOR MEDICARE CONTRACT.

_____ _____
SIGNATURE DATE

Patient Information

What is an Allergist?

An allergist is a specialist who has had training in internal medicine or pediatrics and subsequently special training in the field of allergy and immunology, which diagnoses and treats allergic diseases. These diseases include seasonal and/or year-round nasal or eye symptoms, nasal polyps, asthma, hives, food allergies, insect sting allergy and certain drug allergies.

Your physicians in this office are certified allergy specialists, Diplomates of the American Board of Allergy and Immunology (a cojoin board of Internal Medicine and the American Board of Pediatrics) as well as fellows of the American Academy of Allergy and Immunology.

Will I still need a Family Physician?

Because we are specialists, we do not provide primary care. If you do not already have a primary care physician, we will be glad to assist you in finding one. Routine physicals, non-allergic problems, acute infections and emergencies should be referred to your primary physician. We will send a report on your allergy evaluation to your referring physician. We will provide continuing outpatient care of your allergy problems.

Insurance

It is your responsibility as a patient to understand the terms of your insurance policy. This includes obtaining a valid referral before services can be rendered by this office. The patient is responsible for any charges not covered by their insurance policy including co-pays and deductibles, or if a valid referral was not obtained.

Appointments

Patients are seen by appointment Monday through Friday. The office is open Monday 9:00 a.m. to 5:30 p.m., Tuesday through Thursday 9:00 a.m. to 6:00 p.m., and Friday 9:00 a.m. to 4:00 p.m. Call (703) 689-2000 to make an appointment. Please call several months prior to when the appointment should be scheduled.

Cancellations

If you are unable to keep an appointment, please call the office as soon as possible. We request that cancellations be made at least 24 hours in advance as this allows us to give you and all our patients better service. If the office is closed, please call the answering service at (703) 255-4590. Appointments not cancelled within 24 hours will result in charge of $25.00.

Prescription Refills

We will be glad to refill routine prescriptions during our regular office hours. Just have your pharmacist call during regular office hours, and we will refill prescriptions over the telephone. Office policy is that patients are required to have been seen within the past year in order to have a prescription refilled. Refills made after office hours will be assessed a charge of $10.00.

Telephone Calls

Please feel free to call during office hours if you have any questions regarding your condition, medications or therapy. If our medical assistants are unable to answer your questions, then a physician will return your call. If you have an emergency, the primary doctor should be notified first. If an admission to the hospital is necessary, this can be done by your family physician. We will be glad to consult with him or her concerning any allergic factors at his or her request.

_____ _____

Signature of Patient/Parent if Minor Date

Adult and Pediatric Allergy Center of Northern Virginia

Donna L. Schuster, M.D.
Ngoc Tran Vu, M.D.
Diplomates, American Board of Allergy and Immunology
Anna Lisowski, F.N.P.

100 Elden Street, Suite10
Herndon, Virginia 20170

Phone: 703-689-2000
Fax: 703-478-6612

EMERGENCY CONTACT INFORMATION

PATIENT NAME_____ **DATE OF BIRTH**_____

If patient is a minor please include parents information:

PARENT NAME_____

HOME #_____ WORK #_____

CELL #_____

PARENT NAME_____

HOME #_____ WORK #_____

CELL #_____

EMERGENCY CONTACTS

Please provide two emergency contacts.

NAME_____

RELATIONSHIP_____

HOME #_____ **WORK #**_____

CELL #_____

NAME_____

RELATIONSHIP_____

HOME #_____ **WORK #**_____

CELL #_____